General

Guideline Title

American Society of Interventional Pain Physicians (ASIPP) guidelines for responsible opioid prescribing in chronic non-cancer pain: part 2 - guidance.

Bibliographic Source(s)

Manchikanti L, Abdi S, Atluri S, Balog CC, Benyamin RM, Boswell MV, Brown KR, Bruel BM, Bryce DA, Burks PA, Burton AW, Calodney AK, Caraway DL, Cash KA, Christo PJ, Damron KS, Datta S, Deer TR, Diwan S, Eriator I, Falco FJ, Fellows B, Geffert S, Gharibo CG, Glaser SE, Grider JS, Hameed H, Hameed M, Hansen H, Harned ME, Hayek SM, Helm S 2nd, Hirsch JA, Janata JW, Kaye AD, Kaye AM, Kloth DS, Koyyalagunta D, Lee M, Malla Y, Manchikanti KN, McManus CD, Pampati V, Parr AT, Pasupuleti R, Patel VB, Sehgal N, Silverman SM, Singh V, Smith HS, Snook LT, Solanki DR, Tracy DH, Vallejo R, Wargo BW. American Society of Interventional Pain Physicians (ASIPP) guidelines for responsible opioid prescribing in chronic non-cancer pain: part 2 - guidance. Pain Physician. 2012 Jul;15(3 Suppl):S67-S116. [483 references] PubMed

Guideline Status

This is the current release of the guideline.

This guideline updates a previous version: Trescot AM, Helm S, Hansen H, Benyamin R, Glaser SE, Adlaka R, Patel S, Manchikanti L. Opioids in the management of chronic non-cancer pain: an update of American Society of the Interventional Pain Physicians' (ASIPP) guidelines. Pain Physician 2008 Mar-Apr;11(2S):S5-62.

Regulatory Alert

FDA Warning/Regulatory Alert

Note from the National Guideline Clearinghouse: This guideline references a drug(s) for which important revised regulatory and/or warning information has been released.

Drug Withdrawal

- July 14, 2005 – Palladone (hydromorphone hydrochloride) : The U. S. Food and Drug Administration (FDA) issued a public health advisory to notify health care professionals and consumers that the sponsor of Palladone, Purdue Pharma, has agreed to suspend sales and marketing of Palladone (hydromorphone hydrochloride, extended release capsules), a potent narcotic painkiller, because of the potential for severe side effects if Palladone is taken with alcohol. Drinking alcohol while taking Palladone may cause rapid release of hydromorphone, leading to high drug levels in the body, with potentially fatal effects. High drug levels of hydromorphone may depress or stop breathing, cause coma, and even cause death.

Additional Notices

- August 31, 2016 – Opioid pain and cough medicines combined with benzodiazepines : A U.S. Food and Drug Administration (FDA) review has found that the growing combined used of opioid medicines with benzodiazepines or other drugs that depress the central nervous system (CNS) has resulted in serious side effects, including slowed or difficult breathing and deaths. FDA is adding Boxed Warnings to the drug labeling of prescription opioid pain and prescription opioid cough medicines and benzodiazepines.
- March 22, 2016 – Opioid pain medicines : The U.S. Food and Drug Administration (FDA) is warning about several safety issues with the entire class of opioid pain medicines. These safety risks are potentially harmful interactions with numerous other medications, problems with the adrenal glands, and decreased sex hormone levels. They are requiring changes to the labels of all opioid drugs to warn about these risks.

Recommendations

Major Recommendations

Definitions for the strength of the evidence (good, fair, or limited) are provided at the end of the "Major Recommendations" field.

Initial Steps of Opioid Therapy

1. Comprehensive assessment and documentation is recommended before initiating opioid therapy, including documentation of comprehensive history, general medical condition, psychosocial history, psychiatric status, and substance use history. (Evidence: good)
2. Despite limited evidence for reliability and accuracy, screening for opioid use is recommended, as it will identify opioid abusers and reduce opioid abuse. (Evidence: limited)
3. Prescription monitoring programs must be implemented due to regulations, as they provide data on patterns of prescription usage, reduce prescription drug abuse or doctor shopping, and prescription drug monitoring programs (PDMPs) may reduce emergency room visits, drug overdoses, or deaths. (Evidence: good to fair)
4. Urine drug testing (UDT) must be implemented from initiation along with subsequent adherence monitoring, in an in office setting with immunoassay and confirmation for accuracy with chromatography in select cases, to identify patients who are non-compliant or abusing prescription drugs or illicit drugs, and urine drug testing may decrease prescription drug abuse or illicit drug use when patients are in chronic pain management therapy. (Evidence: good)

Establishing Diagnosis

1. Establish appropriate physical diagnosis and psychological diagnosis if available prior to initiating opioid therapy. (Evidence: good)
2. Caution must be exercised in ordering various imaging and other evaluations, and only appropriate information in the realm of clinical relevance shall be provided by the treating physician to the patients when there is correlation of the symptoms with findings; to avoid increased fear, activity restriction, requests for increased opioids, and maladaptive behaviors. (Evidence: good)
3. A pain management consultation, for non-pain physicians, if high-dose opioid therapy is being utilized. (Evidence: fair)

Establishing Medical Necessity

1. It is essential to establish medical necessity prior to initiation or maintenance of opioid therapy. (Evidence: good)

Establishing Treatment Goals

1. It is essential to establish treatment goals of opioid therapy with regard to pain relief and improvement in function. (Evidence: good)

Assessment of Effectiveness of Opioid Therapy

1. Clinicians must understand the effectiveness and adverse consequences of long-term opioid therapy in chronic non-cancer pain and its limitations. (Evidence: fair for short-term, limited for long-term)
2. The long-acting opioids in high doses are recommended only in specific circumstances with severe intractable pain that is not amenable to short-acting or moderate doses of long-acting opioids, as there is no significant difference between long-acting and short-acting opioids for their effectiveness or adverse effects. (Evidence: fair)
3. A trial of opioid rotation may be considered for patients requiring escalating doses. (Evidence: limited)
4. It is recommended that contraindications to opioid use in chronic non-cancer pain must be evaluated including respiratory instability, acute psychiatric instability, uncontrolled suicide risk, active or history of alcohol or substance abuse, confirmed allergy to opioid agents, coadministration of drugs capable of inducing life-limiting drug interaction, concomitant use of benzodiazepines, active diversion of controlled

substances, and concomitant use of heavy doses of central nervous system depressants, such as benzodiazepines. (Evidence: fair to limited)

Informed Decision-Making

1. A robust agreement which is followed by all parties is essential in initiating and maintaining opioid therapy, as such agreements reduce overuse, misuse, abuse, and diversion. (Evidence: fair)

Initial Treatment

1. Once medical necessity is established, opioid therapy may be initiated with low doses and short-acting drugs with appropriate monitoring to provide effective relief and avoid side effects. (Evidence: fair for short-term effectiveness, limited for long-term effectiveness)
2. Up to 40 mg of morphine equivalent doses are being recommended as low dose, 41 to 90 mg of morphine equivalent dose as a moderate dose, and greater than 91 mg of morphine equivalence as high doses. (Evidence: fair)
3. In reference to long-acting opioids, titration must be carried out with caution and overdose and misuse must be avoided. (Evidence: good)
4. Methadone is recommended for use in late stages after failure of other opioid therapy and only by clinicians with specific training in the risks and uses. (Evidence: limited)

Adherence Monitoring

1. Monitoring recommendation for methadone prescription is that an electrocardiogram should be obtained prior to initiation, at 30 days and yearly thereafter. (Evidence: fair)
2. In order to reduce prescription drug abuse and doctor shopping, adherence monitoring by urine drug testing and PMDPs provide evidence that is essential to the identification of those patients who are non-compliant or abusing prescription drugs or illicit drugs. (Evidence: fair)

Monitoring and Managing Side Effects

1. It is essential to monitor for side effects and manage them appropriately including discontinuation of opioids if indicated. (Evidence: fair)
2. Constipation must be closely monitored and a bowel regimen be initiated as soon as deemed necessary. (Evidence: good)
3. It is recommended that a policy of driving under the influence of drugs be developed and monitored during initiation of therapy, changes in the dosages, and addition of other centrally acting agents. (Evidence: good)

The Final Phase

1. Chronic opioid therapy may be continued, with continuous adherence monitoring, modified at any time during this phase, with fair evidence showing effectiveness of opioids in well-selected populations, in conjunction with or after failure of other modalities of treatments with improvement in physical and functional status and minimal adverse effects. (Evidence: fair)
2. Methadone is recommended for use in late stages after failure of other opioid therapy and only by clinicians with specific training in the risks and uses. (Evidence: limited)
3. A trial of opioid rotation may be considered for patients requiring escalating doses. (Evidence: limited)
4. Chronic opioid therapy should be monitored for adverse effects and to manage them appropriately. (Evidence: good)

Definitions:

Strength of Evidence

Grade	Definition
Good	Evidence includes consistent results from well-designed, well-conducted studies in representative populations that directly assess effects on health outcomes (at least 2 consistent, higher-quality randomized controlled trials (RCTs) or studies of diagnostic test accuracy).
Fair	Evidence is sufficient to determine effects on health outcomes, but the strength of the evidence is limited by the number, quality, size, or consistency of included studies; generalizability to routine practice; or indirect nature of the evidence on health outcomes (at least one higher-quality trial or study of diagnostic test accuracy of sufficient sample size; 2 or more higher-quality trials or studies of diagnostic test accuracy with some inconsistency; at least 2 consistent, lower-quality trials or studies of diagnostic test accuracy, or multiple consistent observational studies with no significant methodological flaws).
Limited, lack of evidence, or poor	Evidence is insufficient to assess effects on health outcomes because of limited number or power of studies, large and unexplained inconsistency between higher-quality trials, important flaws in trial design or conduct, gaps in the chain of evidence, or lack of information on important health outcomes.

Adapted and modified from methods developed by U.S. Preventive Services Task Force (USPSTF).

Clinical Algorithm(s)

Clinical algorithms are provided in the original guideline document for the following:

- Guidance to opioid therapy
- Risk stratification and adherence monitoring
- Algorithmic steps in urine drug testing in chronic pain

Scope

Disease/Condition(s)

Chronic non-cancer pain

Guideline Category

Counseling

Diagnosis

Evaluation

Management

Risk Assessment

Screening

Treatment

Clinical Specialty

Anesthesiology

Internal Medicine

Neurology

Physical Medicine and Rehabilitation

Psychiatry

Psychology

Rheumatology

Intended Users

Health Care Providers

Other

Physicians

Guideline Objective(s)

- To provide clear and concise guidelines to physicians to improve patient access and avoid diversion and abuse
- To provide guidance for the use of opioids for the treatment of chronic non-cancer pain, to produce consistency in the application of an opioid philosophy among the many diverse groups involved, to improve the treatment of chronic non-cancer pain, and to reduce the incidence of abuse and drug diversion
- To improve the quality of care, patient access, treatment outcomes, appropriateness of care, deficiency and effectiveness, and achieve cost containment by improving the cost-benefit ratio

Target Population

Patients with chronic moderate to severe pain of non-cancer origin who may be eligible for appropriate medically necessary opioid analgesic management, within an algorithmic approach of chronic pain management, and within the boundaries of responsible opioid prescribing

Note: This management may include or be independent of other modalities of treatments including interventional techniques.

Interventions and Practices Considered

Evaluation/Diagnosis/Risk Assessment/Screening

1. Comprehensive assessment and documentation before initiating opioid therapy (comprehensive history, general medical condition, psychosocial history, psychiatric status, and substance use history)
2. Screening for opioid use to identify opioid abusers
3. Implementation of prescription monitoring programs
4. Urine drug testing (UDT) (immunoassay and confirmation for accuracy with chromatography in select cases)
5. Establishing appropriate physical diagnosis and psychological diagnosis before initiating opioid therapy
6. Pain management consultation for non-pain physicians (if high-dose opioid therapy is used)
7. Establishing medical necessity before initiation or maintenance of opioid therapy

Treatment/Management

1. Establishing treatment goals of opioid therapy with regard to pain relief and improvement in function
2. Understanding effectiveness and adverse effects of opioid therapy (long-acting versus short-acting opioids)
3. A trial of opioid rotation for patients requiring escalating doses
4. Evaluation of contraindications to opioid use
5. Informed decision-making, including agreements on opioid use, misuse, and diversion
6. Initiation of opioid therapy (e.g., morphine) at low doses and short-acting drugs with appropriate monitoring
7. Titration of long-acting opioids
8. Methadone use in late stages after failure of other opioid therapy
9. Adherence monitoring (electrocardiogram for methadone, UDT, prescription drug monitoring programs)
10. Monitoring and managing side effects, especially constipation

Major Outcomes Considered

- Effectiveness of opioids in the treatment of chronic pain
    - Symptom control
    - Quality of life
    - Emotional well-being
    - Functional status
- Rate of unemployment
- Adverse and comorbid effects of opioids in the treatment of chronic pain

- Sensitivity of drug testing assays for opioids
- Prevalence of controlled prescription drug abuse
- Prevalence of drug diversion
- Prevalence of drug interactions
- Cost of opioid use
- Patient access

Methodology

Methods Used to Collect/Select the Evidence

Hand-searches of Published Literature (Primary Sources)

Hand-searches of Published Literature (Secondary Sources)

Searches of Electronic Databases

Description of Methods Used to Collect/Select the Evidence

These guidelines were developed utilizing the evidence review conducted by American Society of Interventional Pain Physicians (ASIPP) with multiple comprehensive reviews and other independent submissions to Pain Physician. The guidelines also utilized multiple previously published guidelines and systematic reviews. The panel screened over 10,000 abstracts from searches for systematic reviews and primary studies from multiple electronic databases, reference lists of relevant articles, and suggestions from expert reviewers. Multiple systematic reviews and primary studies were included in the evidence synthesis with regards to pain relief, side effects, and functional outcomes when treated with opioids. Guidelines and treatment recommendations were based on these reviews. During the process, the panel reviewed published randomized controlled trials (RCTs), meta-analyses, narrative reviews, and clinical practice guidelines concerning the use of opioid analgesics in patients with chronic non-cancer pain.

Number of Source Documents

Not stated

Methods Used to Assess the Quality and Strength of the Evidence

Weighting According to a Rating Scheme (Scheme Given)

Rating Scheme for the Strength of the Evidence

Strength of Evidence

Grade	Definition
Good	Evidence includes consistent results from well-designed, well-conducted studies in representative populations that directly assess effects on health outcomes (at least 2 consistent, higher-quality randomized controlled trials (RCTs) or studies of diagnostic test accuracy).
Fair	Evidence is sufficient to determine effects on health outcomes, but the strength of the evidence is limited by the number, quality, size, or consistency of included studies; generalizability to routine practice; or indirect nature of the evidence on health outcomes (at least one higher-quality trial or study of diagnostic test accuracy of sufficient sample size; 2 or more higher-quality trials or studies of diagnostic test accuracy with some inconsistency; at least 2 consistent, lower-quality trials or studies of diagnostic test accuracy, or multiple consistent observational studies with no significant methodological flaws).
Limited, lack of	Evidence is insufficient to assess effects on health outcomes because of limited number or power of studies, large and unexplained inconsistency between higher-quality trials, important flaws in trial design or conduct, gaps in the chain of evidence,

Grade	Definition
evidence, or poor	or lack of information on important health outcomes.

Adapted and modified from methods developed by U.S. Preventive Services Task Force (USPSTF).

Methods Used to Analyze the Evidence

Review of Published Meta-Analyses

Systematic Review with Evidence Tables

Description of the Methods Used to Analyze the Evidence

Methodological Assessment

The methodology utilized follows the systematic review process derived from an evidence-based review of systematic reviews and meta-analysis of randomized trials and observational studies, Consolidated Standards of Reporting Trials (CONSORT) guidelines for the conduct of randomized trials, Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) guidelines, Cochrane guidelines, and Chou and Huffman's guidelines.

The guideline preparation considered systematic reviews, comprehensive reviews, and randomized controlled trials (RCTs), and observational studies of critical importance that were published after the publication of the systematic reviews.

Analysis of Evidence

The analysis of the evidence was performed based on United States Preventive Services Task Force (USPSTF) criteria as illustrated in the "Rating Scheme for the Strength of the Evidence" field, criteria which have been utilized by others. The analysis was conducted using 3 levels of evidence; good, fair, or limited (i.e., lack of evidence or poor).

Methods Used to Formulate the Recommendations

Expert Consensus

Description of Methods Used to Formulate the Recommendations

Panel Composition

American Society of Interventional Pain Physicians (ASIPP) convened a multidisciplinary panel of 56 experts in various fields to review the evidence and formulate recommendations for chronic opioid therapy in non-cancer pain. The panel has been instructed to answer questions and develop evidence pertaining to important aspects of opioid therapy. Members of the panel were also requested to develop comprehensive reviews on various related subjects in preparation for the opioid guidelines. Other independent submissions were also considered. The panel members convened in person on 3 occasions in Memphis, Tennessee, during other workshops conducted by ASIPP, and also had 5 webinars and/or telephone conferences. The majority of the participants attended multiple meetings.

The committee provided a broad representation of academic and non-academic clinical practitioners, representing a variety of practices and geographic areas, all with interest and expertise in opioid use and management of patients with chronic non-cancer pain. The committee formulized the elements of the guidelines preparation process, including literature searches, literature synthesis, consensus evaluation, open forum presentations, and formal endorsement by the ASIPP Board of Directors and peer review.

Guideline Development Process

The guidelines panel met on multiple occasions. At the first meeting, the panel defined the scope and development of recommendations for important aspects to guide the systematic evidence review and synthesis. During the course of multiple meetings the sub-panels reviewed the results of the evidence review and drafted potential recommendations. The final consensus was carried out by electronic communication with further discussions, revisions, and final recommendations approved by at least two-thirds of the majority.

Rating Scheme for the Strength of the Recommendations

Not applicable

Cost Analysis

Published cost analyses were reviewed.

Method of Guideline Validation

Peer Review

Description of Method of Guideline Validation

Not stated

Evidence Supporting the Recommendations

Type of Evidence Supporting the Recommendations

The type of supporting evidence is identified and graded for each recommendation (see the "Major Recommendations" field).

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

The perceived benefits of these guidelines include:

- Increased physician awareness about the current issues involving opioids and non-cancer pain
- Improved patient access
- Reduced level of opioid abuse with responsible prescribing
- Improved ability to manage patient expectations
- Reduced diversion
- Improved understanding by law enforcement about proper prescribing patterns
- Improved cooperation among patients, providers, and regulatory agencies
- Improved understanding by patients regarding their rights, but also an increased awareness of responsibilities and adverse consequences that may occur while taking opioid medications

Potential Harms

- Multiple side effects of opioids, including effect on driving, sedation, constipation, and breathing specifically in patients with respiratory disorders, must be monitored.
- Adverse effects have been commonly reported with nausea in 28%, constipation in 26%, somnolence/drowsiness in 24%, dizziness/vertigo in 18%, dry-skin/itching in 15%, and vomiting in 15% of patients on relatively high-dose opioids. Low-dose opioids, however, have been accompanied by lesser complications. The majority of these adverse effects are resolved with continued treatment and dose adjustments. However, constipation may not be resolved and requires a bowel regimen. Furthermore, with long-term therapy and high doses, other complications may be noted including hypogonadism, neuroendocrine dysfunction, sleep disorders, and hyperalgesia. Other effects which are seen in less than 10% of the population include dry mouth, headache, sexual dysfunction, hot flashes, loss of appetite, abdominal pain, fatigue, sleeplessness/insomnia, sweating, blurred vision/confusion, muscle contractions, diarrhea, ataxia, edema, difficulty urinating, restless

legs, application site reaction, heartburn, anxiety, and weakness. The majority of these complications do resolve except for sexual dysfunction and fatigue, which increase with long-term treatment with hormonal imbalances. However, the complications are more frequent, longer lasting, and severe in long-term high-dose opioid therapy. Peripheral edema, though observed in a small proportion of patients, could be a major issue. Neuroendocrine abnormalities with erectile dysfunction must be taken into consideration and explained to the patient, with appropriate referral when indicated. Similarly sleep apnea and opioid-induced hyperalgesia (OIH) must be handled appropriately. Refer to section 9.0, Monitoring and Managing Side Effects, in the original guideline document for additional information.

- The development of tolerance, dependency, addiction, and hyperalgesia are a major concern.
- Acetaminophen toxicity causes the majority of cases of acute renal failure in the United States. Sub-clinical liver toxicity has been shown to occur with doses below 4 grams per day. Alcohol also competes for the same metabolic pathway as acetaminophen placing heavy drinkers at higher risk for toxicity. Chronic alcohol use is an independent risk factor for mortality in acetaminophen poisoning.
- Morphine can cause toxicity in patients with renal dysfunction. It has been shown that M-6 glucuronide, an active metabolite of morphine, accumulates in the serum of patients and causes central nervous system and respiratory depression. The degree of accumulation was related to the morphine dose and the extent of renal impairment.
- Fentanyl, 80-100 times as potent as morphine, can cause significant central nervous system and respiratory depression and also has been shown to contribute to numerous overdose deaths.
- When switching from codeine to fentanyl, regardless of the codeine dose, caution must be exercised as patients may have little or no opioid tolerance.
- In reference to methadone, even though it has not been shown to be more effective than other opioids, it has been used extensively in the United States and associated with multiple adverse consequences including prolonged QT interval. Methadone has been associated with numerous overdose deaths in pain patients with analgesic use increasing sharply in the United States, with a 1,293% increase from 1997 to 2007.
- Combinations of short- and long-acting, and high doses of long-acting opioids must be prescribed with extreme caution.

Contraindications

Contraindications

Contraindications to opioid use in chronic non-cancer pain that must be evaluated include respiratory instability, acute psychiatric instability, uncontrolled suicide risk, active or history of alcohol or substance abuse, confirmed allergy to opioid agents, coadministration of drugs capable of inducing life-limiting drug interaction, concomitant use of benzodiazepines, active diversion of controlled substances, and concomitant use of heavy doses of central nervous system depressants, such as benzodiazepines.

Qualifying Statements

Qualifying Statements

- These guidelines are developed for use by physicians practicing interventional pain management and do not constitute inflexible treatment recommendations. The guidelines may, however, also be applied to other physicians, as well as practitioners involved in prescribing opioids. These guidelines are not intended to address all possible clinical situations where opioids might be used for non-cancer pain in clinical practices. It is expected that a provider will establish a plan of care on a case-by-case basis, with consideration of individual patients' medical conditions, personal needs, and preferences, as well as the physician's experience. Based on individual patients' needs, a treatment different from the guidance provided and outlined here could be warranted. Thus, these guidelines do not represent the "standard of care."
- The focus of these guidelines is to curtail the abuse of opioids without jeopardizing non-cancer pain management. It is recognized that the management of non-cancer pain takes place in a wide context of health care situations, involving multiple specialties and multiple techniques. However, providers managing acute pain must be cognizant of the fact that once opioid use commences, they are continued in the majority of patients in the chronic phase and throughout their lifetime frequently. Consequently, these guidelines cannot be applied to all patients. The decision to implement a particular management approach should be based on a comprehensive assessment of the patient's overall health status, disease state, preference, and physician training and skill.
- The authors are solely responsible for the content of this article. No statement in this article should be construed as an official position of American Society of Interventional Pain Physicians (ASIPP).

Implementation of the Guideline

Description of Implementation Strategy

An implementation strategy was not provided.

Implementation Tools

Chart Documentation/Checklists/Forms

Clinical Algorithm

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

Institute of Medicine (IOM) National Healthcare Quality Report Categories

IOM Care Need

Living with Illness

IOM Domain

Effectiveness

Patient-centeredness

Safety

Identifying Information and Availability

Bibliographic Source(s)

Manchikanti L, Abdi S, Atluri S, Balog CC, Benyamin RM, Boswell MV, Brown KR, Bruel BM, Bryce DA, Burks PA, Burton AW, Calodney AK, Caraway DL, Cash KA, Christo PJ, Damron KS, Datta S, Deer TR, Diwan S, Eriator I, Falco FJ, Fellows B, Geffert S, Gharibo CG, Glaser SE, Grider JS, Hameed H, Hameed M, Hansen H, Harned ME, Hayek SM, Helm S 2nd, Hirsch JA, Janata JW, Kaye AD, Kaye AM, Kloth DS, Koyyalagunta D, Lee M, Malla Y, Manchikanti KN, McManus CD, Pampati V, Parr AT, Pasupuleti R, Patel VB, Sehgal N, Silverman SM, Singh V, Smith HS, Snook LT, Solanki DR, Tracy DH, Vallejo R, Wargo BW. American Society of Interventional Pain Physicians (ASIPP) guidelines for responsible opioid prescribing in chronic non-cancer pain: part 2 - guidance. Pain Physician. 2012 Jul;15(3 Suppl):S67-S116. [483 references] PubMed

Adaptation

Not applicable: The guideline was not adapted from another source.

Date Released

2006 (revised 2012 Jul)

Guideline Developer(s)

American Society of Interventional Pain Physicians - Medical Specialty Society

Source(s) of Funding

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Guideline Committee

Guidelines Panel

Composition of Group That Authored the Guideline

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Financial Disclosures/Conflicts of Interest

Ten of the 55 authors provided information that they received funding from the industry; however, of these, only 2 (less than 4%) were receiving funding from drug makers and with multidisciplinary authorships (18%) receiving funding for research or engaged in speaking from the industry.

- Dr. Benyamin is a clinical investigator with Epimed and receives research support from Cephalon/Teva, Bio-Delivery Sciences International, Inc., Mundipharma Research GmbH & Co., AstraZeneca, Purdue Pharma, LP, and Theravance.
- Dr. Burton is a consultant for Medtronic and Boston Scientific. He serves on the Speaker's Bureau for Johnson & Johnson, Archimedes, Cephalon, and Jazz.
- Dr. Caraway is a consultant for Medtronic, Inc., Spinal Modulation, Inc., and Vertos, Inc.
- Dr. Datta receives research support from Sucampo Pharmaceuticals and an honorarium from Smith and Nephew.
- Dr. Deer is a consultant and research advisor for Bioness, Medtronic, St. Jude, Spinal Modulation, and Vertos.
- Dr. Falco is a Consultant for St. Jude Medical Inc. and Joimax Inc.
- Dr. Grider is an educational trainer for Vertos Medical
- Dr. Hayek is a consultant for Boston Scientific.
- Dr. Helm is a clinical investigator with Epimed and receives research support from Cephalon/Teva, AstraZeneca, and Purdue Pharma, LP.
- Dr. Hirsch is a consultant for CareFusion and receives royalties for products related to vertebral augmentation. He also participated in an Aetrium focus group and received compensation.
- Dr. A. Kaye is a speaker for Depomed, Inc.
- Dr. Silverman is a Speaker for Purdue Pharma and Reckit Benckiser
- Dr. Vallejo receives research support from Cephalon/Teva, BioDelivery Sciences International, Inc., Mundipharma Research GmbH & Co., AstraZeneca, Purdue Pharma, LP, and Theravance.

Guideline Status

This is the current release of the guideline.

This guideline updates a previous version: Trescot AM, Helm S, Hansen H, Benyamin R, Glaser SE, Adlaka R, Patel S, Manchikanti L. Opioids in the management of chronic non-cancer pain: an update of American Society of the Interventional Pain Physicians' (ASIPP) guidelines. Pain Physician 2008 Mar-Apr;11(2S):S5-62.

Guideline Availability

Electronic copies: Available in Portable Document Format (PDF) from the Pain Physician Journal Web site .

Print copies: Available from the American Society of Interventional Pain Physicians, 2831 Lone Oak Road, Paducah, KY 42003; Phone: (270) 554-9412; Fax: (270) 554-8987; email: asipp@asipp.org.

Availability of Companion Documents

The following is available:

- Manchikanti L, Abdi S, Atluri S, et al. American Society of Interventional Pain Physicians (ASIPP) guidelines for responsible opioid prescribing in chronic non-cancer pain: part 1 - evidence assessment. Pain Physician 2012 Jul;15(3 Suppl):S1-S66. Electronic copies: Available in Portable Document Format (PDF) from the Pain Physician Journal Web site .

Print copies: Available from the American Society of Interventional Pain Physicians, 2831 Lone Oak Road, Paducah, KY 42003; Phone: (270) 554-9412; Fax: (270) 554-8987; email: asipp@asipp.org.

In addition, a sample controlled substance agreement is available in Table 4 in the original guideline document .

Patient Resources

None available

NGC Status

This NGC summary was completed by ECRI on May 8, 2006. The information was verified by the guideline developer on May 19, 2006. This summary was updated by ECRI Institute on July 9, 2008. The updated information was verified by the guideline developer on July 22, 2008. This summary was updated by ECRI Institute on July 20, 2010 following the U.S. Food and Drug Administration advisory on Ultram (tramadol hydrochloride), Ultracet (tramadol hydrochloride/acetaminophen). This summary was updated by ECRI Institute on March 16, 2011 following the U.S. Food and Drug Administration advisory on acetaminophen-containing prescription products. This summary was updated by ECRI Institute on September 21, 2012. This summary was updated by ECRI Institute on October 28, 2013 following the U.S. Food and Drug Administration advisory on Acetaminophen. This summary was updated by ECRI Institute on June 2, 2016 following the U.S. Food and Drug Administration advisory on opioid pain medicines. This summary was updated by ECRI Institute on October 21, 2016 following the U.S. Food and Drug Administration advisory on opioid pain and cough medicines combined with benzodiazepines.

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